DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 04-008	2. STATE New Mexico
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2004	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42CFR Part 440 Services: Subpart A General Provisions; Subpart B, Requirements and Limits Applicable to All Services; 42CFR 440.230	7. FEDERAL BUDGET IMPACT: a. FFY 04 (reduction) ($ 3,141,800) b. FFY 05 (reduction) ($ 12,500,000)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachments: State Supplement A to Attachment 3.1A, pages 5g, 9, 11, 11a, 11b, 12, 13, 17, 18, 19, and 21	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: State Supplement A to Attachment 3.1A, pages 5g, 9, 11, 12, 13, 17, 18, 19, and 21

10. SUBJECT OF AMENDMENT:
Program Limitations for Podiatrists' Services, Dental Services, Prosthetic Devices, DME and Supplies, and Rehabilitative Services; and clarification of limitations and restrictions for EPSDT

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Authority Delegated to the Medicaid Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL: C. Ingram	16. RETURN TO: Carolyn Ingram, Director Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504
13. TYPED NAME: Carolyn Ingram	
14. TITLE: Director, Medical Assistance Division	
15. DATE SUBMITTED: June 28, 2004	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2 JULY 2004	18. DATE APPROVED: 23 SEPTEMBER 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 JULY 2004	20. SIGNATURE OF REGIONAL OFFICIAL: Shirley Glaspie for Andrew A. Fredrickson
21. TYPED NAME: ANDREW A. FREDRICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

FORM HCFA-179 (07-92)

State Supplement A to Attachment 3.1A

Specific program coverage restrictions, limitations in duration or service, and limitations in frequency of service, as described elsewhere in State Supplement A to Attachment 3.1A.

(a) Experimental procedures are limited as described in Item 5, State Supplement A to Attachment 3.1A.

(b) Documentation requirements must be met for abortion services, sterilization services, and hysterectomies.

(c) Limitations in duration and frequency of service otherwise described in the state plan are not applicable when documented as medically necessary for the recipient.

STATE New Mexico
DATE REC'D 7-2-04
DATE APPV'D 9-23-04
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SUPERSEDES T.N. 99-06

State Supplement A to Attachment 3.1A

Item 6a Podiatrists' Services

a. Medicaid coverage is limited to the podiatrist's scope of practice as defined by state law.

b. Foot care services ordinarily considered to be routine are covered only if medically necessary due to the medical condition of the recipient.

c. Certain procedures are to be performed in the office, clinic, or as an outpatient institutional service as an alternative to hospitalization.

d. Services directed toward the care or correction of a flat foot condition are not covered.

e. Orthopedic shoes and other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe, however, if it is an integral part of a leg brace.

f. Surgical or non-surgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered unless documented to be medically necessary. Surgical correction of a subluxated foot structure that is an integral part of the treatment for foot pathology is covered if medically necessary based on the medical condition of the recipient.

Item 6b Optometrists' Services

Orthoptic assessment and treatment are not covered by the New Mexico Medical Assistance Program.

Item 6d Other Practitioners' Services

I. Psychologists

a. The following services are not benefits of the program:

1. Hypnotherapy

2. Biofeedback

State Supplement A to Attachment 3.1A

Item 7a **Intermittent or part time nursing services provided by a home health agency, etc.**

All home health agency services beyond the initial visit for evaluation purposes require prior approval. The medical necessity criteria that a recipient must meet to receive home health services includes the determination that the individual is physically unable or has great difficulty leaving the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization.

Item 7b **Home health aide services provided by a home health agency**

Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff member. The registered nurse or other professional staff member must make a supervisory visit to the recipient's residence at least every two weeks to observe and determine whether goals are being met.

Item 7c **Medical supplies, equipment, and appliances suitable for use in the home**

Medical supplies must be necessary and reasonable to the treatment plan

Durable medical equipment (DME) is considered for coverage only if it is reasonable and necessary for treatment of an illness or injury, or to improve the functioning of a body part. A list is available from the Medical Assistance Division identifying items that require prior approval.

Coverage is limited to services and items that are medically necessary for treatment of a medical condition and do not include the following unless specific medical justification can be made:

1. Items that do not primarily and customarily serve a therapeutic purpose and/or are generally used only for comfort or convenience purposes;

2. Environment control equipment not primarily medical in nature;

3. Institutional equipment inappropriate for home use;

4. Items not generally accepted by the medical professional as being therapeutically effective or are determined by Medicare regulations not to be effective or necessary;

5. Items primarily hygienic in nature rather than medical;

6. Hospital or physician diagnostic items not appropriate for home use;

7. Instruments or devices manufactured for use by a physician or other practitioner not appropriate for home use;

8. Items for administration of heat that are primarily for convenience and not essential to administration of heat therapy

9. Exercise equipment not primarily medical in nature;

10. Items which produce no demonstrable or proven therapeutic effect;

11. Support exercise equipment primarily for institutional use where, in the home setting other devices more appropriately satisfy the recipient's need;

12. Devices for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker not otherwise medically necessary;

13. Items used to improve appearance or are primarily for comfort purposes rather than therapeutic purposes;

14. Items to have available as a precaution not otherwise medically necessary;

15. Emergency communications systems not serving a therapeutic purpose;

16. Oral dietary formula and food products to meet dietary needs in the absence of an inborn metabolic disorder and unless documented as medically necessary and serving a distinct therapeutic need.

17. Pressure support stockings other than those prescribed and custom fitted to meet the needs of the recipient.

Multiple redundant services are not covered. Equipment and supplies are limited in frequency consistent with reasonable use for the medical condition unless justified by a change in the recipient's condition.

Interest and/or carrying charges are not covered.

The delivery of DME is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

Item 7d **Physician therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation center.**

Therapy must be provided by a qualified physiotherapist, occupational therapist or assistant, speech pathologist, or audiologist as per 42 CFR 440.100, and in conformance with state law and in accordance with an approved plan of treatment.

State Supplement A to Attachment 3.1A

Item 9 Clinical Services

a. Limitations for physicians, item 5, also apply to clinics.

b. Ambulatory surgical center facility services are covered when all the following conditions are met:

1. The surgical procedure and use of the facility is medically necessary and is a benefit of the program.

2. All program requirements for the surgery are met by the physician such as valid consent forms, prior approval requirements, etc.

c. Dialysis Services

1. The New Mexico Medicaid Program will reimburse providers for renal dialysis services for the first three months of dialysis if not covered by Medicare pending the establishment of Medicare eligibility.

2. The New Mexico Medicaid Program will cover fifteen sessions of dialysis training sessions without special medical justification. Additional sessions require medical justification be attached to the claim.

SUPERSEDES TN: 89-10

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State Supplement A to Attachment 3.1A

Item 10 Dental Services

New Mexico Medicaid Program does not cover dental services performed for aesthetic or cosmetic purposes only.

Services for which medical necessity may be questionable are covered only with prior approval (or on retrospective approval in emergency situations or following retroactive eligibility). A complete list of those services may be obtained from New Mexico Medical Assistance Division.

SUPERSEDES: TN- 89-10

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Item 12(b) Dentures

Partial dentures, full upper, and/or full lower dentures require prior approval.

Item 12(c) Prosthetic Devices

a. All prosthetic devices require prior approval except for prosthetic limbs attached immediately following surgery for traumatic injuries while the recipient is a hospital inpatient.

b. The following prosthetics and orthotics are not benefits of the program:

1. Orthopedic shoes unless they are an integral part of a leg brace(s).

2. Orthotic supports for the arch or other supportive devices for the foot unless they are integral parts of a leg brace.

3. Prosthetic devices or implants that are primarily for cosmetic purposes are not a benefit of the program unless otherwise determined to be medically necessary for the recipient.

Replacements are limited in frequency unless there has been a change in the recipient's medical condition or the item has exceeded its expected duration of use.

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d. Hearing Aids

1. The following services are covered by the Medical Assistance Programs but require approval from the Medical Assistance Program prior to providing the service:

(a) Hearing aid dispensing, purchase, rentals, and replacements.

(b) Hearing aid repairs exceeding $100.

SUPERSEDES TN. 89-10

State Supplement A to Attachment 3.1A

10. Are items which produce no demonstrable therapeutic effect (i.e., Myoflex muscle stimulator);

11. Are items of support exercise equipment primarily for institutional use (i.e., parallel bars) where, in the home setting, other devices satisfy the recipient's need (e.g., a walker);

12. Are not reasonable or necessary for monitoring the pulse of a homebound recipient with or without a cardiac pacemaker (e.g., pulse tachometer);

13. Are used to improve appearance or for comfort purposes (i.e., sauna baths, wigs);

14. Are precautionary in nature (i.e., spare tanks of oxygen in addition to a portable backup system);

15. Are emergency communications systems and do not serve a therapeutic purpose.

Multiple services are not covered. Recipients are limited to one wheelchair, one hospital bed, etc. Supplies are limited in frequency consistent with reasonable use for the medical condition.

Interest and/or carrying charges are not covered.

The delivery of D.M.E. is covered only when the equipment is initially purchased or rented; when the supplier customarily makes a separate charge for delivery; and only for delivery charges of over 75 miles (round trip).

Pressure support stockings are limited to those custom fitted for the recipient.

Nutritional products are limited to enterally and intravenously administered products. Oral nutritional products are not covered for routine dietary needs in the absence of inborn metabolic disorders and documented medical necessity.

SUPERSEDES: TN 89-10

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4. Contact Lenses, except when prior authorized.

5. Glass cases, anti-scratch lenses, anti-reflective coatings, progressive lenses, trifocals and other items not related to medical necessity.

6. Routine vision exams and glasses are allowed only once in a 24-month period except as provided as an EPSDT service or the medical condition of the client requires more frequent examination, treatment or follow up.

Item 13 d Rehabilitative Services

Services are limited to mental health rehabilitation services for eligible recipients for whom the medical necessity of such services has been determined and who are not residents of an institution for mental illness.

The services are limited to goal oriented mental health rehabilitative services individually designed to accommodate the level of the recipient's functioning and which reduce the disability and to restore the recipient to his/her best possible level of functioning.

Services are limited to assessment, treatment planning, and specific services which reduce symptomatology and restore basic skills necessary to function independently in the community including:

1. Therapeutic Interventions: Provides face to face therapeutic services which include assessments, treatment planning, ongoing treatment, and transition planning.

2. Medication Services: Provides for the assessment of the efficacy of medication and evaluation of side effects, and administration of medication by qualified personnel when it cannot be self administered. Also provides educationally structured face to face activities delivered to patients, their families and others who provide care to patients regarding medication management.

3. Community Based Crisis Interventions: Provides coordinated services utilizing a crisis team. The service includes immediate access, evaluation, crisis intervention and respite care to patients.

4. Professional Consultation: Provides consultation services by mental health professionals as part of treatment team, to patients for the purpose of clinical case review, treatment plan development and ongoing treatment.

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